Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Geneva Medical MGMT P.O. Box 121589 Arlington, TX 76012	MFDR Tracking #: M4-08-1942-01 DWC Clai Injured Employ Date of Inju Employer Nar Insurance Carrier
Respondent Name and Box #: Northside ISD Rep. Box # 03	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "Not paid per fee schedule."

Principal Documentation:

1. DWC060 package
2. Total Amount Sought - $150.00
3. CMS 1500
4. EOBs
5. Medical narrative report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary as taken from Table of Disputed Services: "DRE Method was used to render the impairment to the left knee. The MMI portion of the exam is reimbursed at $350.00. One body area rated using the DRE Method is paid at an additional $150.00 for a total payment of $500.00, which is what the requestor was paid."

1. Response to DWC060

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes	Denial Codes	Part V Reference	Amount Ordered
08/09/07	99546-26	W1, 309SW, D099	1 - 6	$120.00
08/09/07	99546-TC	W1, 309SW, D099	1 - 6	$30.00
Total Due:				$150.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

On March 24, 2008, the Division contacted the Requestor's representative, Mary, and verified services remain in dispute.

1. These services were denied by the Respondent with reason code "W1-Workers Compensation State Fee Schedule Adjustment" and "309SW-CHARGE EXCEEDS FEE SCHEDULE ALLOWANCE."

2. The Respondent denied reimbursement based upon "D099-Payment is denied as our records indicated that this is an exact duplicate charge for a service that has been paid or is in process." The disputed service was a duplicate bill submitted for reconsideration of payment.

3. According to Rule 134.202(e)(6)(C)(iii), "An examining doctor, other than the treating doctor, shall bill using the 'Work related or medical disability examination by other than the treating physician...' CPT code. Reimbursement shall be $350."

4. According to Rule 134.202(e)(6)(D)(II), "The MAR for musculoskeletal body areas shall be as follows.
   a) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th Edition is used.
   b) If full physical evaluation, with range of motion is performed:
      1) $300 for the first musculoskeletal body area; and
      2) $150 for each additional musculoskeletal body area.

5. According to Rule 134.202(e)(6)(D)(III), "If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with the modifier "WP." Reimbursement shall be 100% of the total MAR." The Requestor did not utilize modifier "WP" when billing for the whole procedure as outlined in statute, instead they billed the professional and technical services separately.

6. On this date, the Requestor billed $650.00 for CPT code 99456-26 and $650.00 for CPT code 99456-TC for a total of $1300.00. Per Advisory 2004-01, the Requestor performed MMI and IR evaluation of one body area. Per Rule 134.202(e)(6)(C)(iii), the Requestor is entitled to reimbursement of $350.00 for MMI evaluation. Also, Rule 134.202(e)(6)(D)(iii)(II) allows reimbursement of $300.00 for IR performed with full physical and ROM method for the lower extremity area of the left knee. Rule 134.202(e)(6)(D)(iii)(II)(a) allows reimbursement of $150.00 for IR-DRE method. A review of the narrative report reveals that ROM goniometer measurements were performed by a certified technician, yielding a 0% impairment rating. Another determination of 2% impairment per the narrative was "based on the partial medial meiscectomy" by the Diagnosis Related Estimates (DRE) methodology, as per Table 64, page 85 of the AMA Guides to the Evaluation of Permanent Impairment, 4th Edition, 4th Printing, October 1999. The ROM determined values of 0% and DRE table determined 2% impairment were combined, obtaining the 1% IR. As a note, the knee is not typically a DRE area to evaluate as would be the spinal region. Per DWC bulletins, "If the evaluator must use the ROM method to obtain the correct IR of a DRE area, the evaluator should bill and be reimbursed for performing the ROM method. Although, the evaluator is reimbursed at the ROM rate in this situation, the evaluator is not reimbursed both the DRE and the ROM amounts." Therefore, the Requestor is entitled to total reimbursement of $650.00 for CPT codes 99456-TC and 99456-26 combined. The insurance carrier paid $400.00 for 99456-26 and $100.00 for 99456-TC. Subtracting the $500.00 amount reimbursed previously from the MAR, the Requestor is due an additional $150.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code, Rules 134.1, 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to **additional** reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$150.00** plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

[redacted]

Authorized Signature | Medical Fee Dispute Resolution Officer | 05/12/08 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.